

**CASH OPTION****ENROLLMENT AUTHORIZATION**

STD. 701C (REV 5-94)

**FLEXELECT PROGRAM****C**

*Please type or use ball point pen, print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office*

**SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY**

1. ENROLLMENT (Check appropriate box)		2. SOCIAL SECURITY NUMBER
A. <input type="checkbox"/> Open Enrollment	C. <input type="checkbox"/> Change Due to Permitting Event	3. NAME (First, Initial, Last)
B. <input type="checkbox"/> Newly Eligible Enrollment	D. <input type="checkbox"/> Cancellation	

**PLAN ELECTIONS - REFER TO THE FLEXELECT ENROLLMENT BROCHURE FOR CASH OPTION ELECTION INFORMATION AND PROCEDURES FOR COMPLETING THIS FORM**

BENEFIT ITEM	ENTER MONTHLY CASH OPTION AMOUNT AND TOTAL	5. For SCO Use Only Type of Change
4. <b>Cash Option 354-001</b>	A. <b>Medical</b> \$ _____ B. <b>Dental</b> \$ _____ C. <b>Total Cash Option</b> \$ _____	

**6. STATEMENT OF OTHER MEDICAL AND/OR DENTAL COVERAGE**

I certify that I am covered by another group medical and/or dental insurance plan as indicated below. I certify that I will maintain coverage in this medical and/or dental insurance plan on an ongoing basis and I agree to notify my Personnel Office within 60 days if I lose coverage.

A. MEDICAL INSURANCE CARRIER'S NAME	C. OTHER COVERAGE THROUGH (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Other employer <input type="checkbox"/> Privately maintained
B. DENTAL INSURANCE CARRIER'S NAME	D. IF YOUR MEDICAL AND/OR DENTAL INSURANCE IS THROUGH YOUR SPOUSE, COMPLETE THIS ITEM <b>Spouse's Employer</b> <b>Spouse's Social Security Number</b> <input type="checkbox"/> State <input type="checkbox"/> Other

**7. I UNDERSTAND THAT MY FLEXELECT CASH OPTION ENROLLMENT IN LIEU OF MEDICAL AND/OR DENTAL COVERAGE WILL CONTINUE FROM YEAR TO YEAR UNTIL I TAKE ACTION TO CHANGE OR CANCEL MY ENROLLMENT.**

**IF I AM A PERMANENT INTERMITTENT EMPLOYEE I UNDERSTAND THAT THIS CONTINUOUS ENROLLMENT DOES NOT APPLY TO ME AND THAT I MUST REENROLL EACH YEAR AS OUTLINED IN THE FLEXELECT BROCHURE.**

I have reviewed the brochure describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during my entire period of enrollment unless I have a "Family Status Change" as defined in these regulations or other permitting events as described in the FlexElect Brochure. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

**I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT BROCHURE.**

EMPLOYEE SIGNATURE	DATE SIGNED
	

**AGENCY USE ONLY**

8. EFFECTIVE DATE OF ACTION MO   DAY   YEAR   -1-	9. EMPLOYEE CBID	10. PERMITTING EVENT DATE MO   DAY   YEAR	11. PERMITTING EVENT CODE	
12. HEALTH FORM ATTACHED (HBD - 12) <input type="checkbox"/> YES <input type="checkbox"/> NO	13. DENTAL FORM ATTACHED (STD. 692) <input type="checkbox"/> YES <input type="checkbox"/> NO	14. PERMANENT INTERMITTENT <input type="checkbox"/> YES <input type="checkbox"/> NO	15. AGENCY CODE	16. UNIT CODE
17. REMARKS		18. AGENCY NAME		
		19. AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.		
		20. DATE RECEIVED IN EMPLOYING OFFICE (mo   day   year)		
		21. TELEPHONE NUMBER (Indicate if CALNET or give area code)		

**DISTRIBUTION:** Original - State Controller's Office; Pink - Agency; Goldenrod - Employee

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STD. 701C (REV 5-94) (REVERSE)

**FLEXELECT PROGRAM**

**PRIVACY NOTICE**

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the plan administrator for the purposes of identification and document processing.

It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in FlexElect enrollment elections not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form may be forwarded to the plan administrator. Copies of the FlexElect Cash Option Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Cash Option Enrollment Authorization forms upon request. The official responsible for access of the form is: Chief of Personnel/Payroll Operations Branch, State Controller's Office, P.O. Box 942850, Sacramento, California 94250-5878.